

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-034501

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317

Primary Registration District No. 547

Registrar's No. 2367

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 23 1963

1. PLACE OF DEATH a. COUNTY St. Louis,		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN St. Louis,	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hosp.		d. STREET ADDRESS 6737 Wise	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type, or, print) First Middle Last William Joseph Mc Dermott		4. DATE OF DEATH Month Day Year July 25 1963	
5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-26-1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY Van Loan Co. N.Y.	9. AGE (last birthday) 83 IF UNDER 1 YEAR Months Days Hours Min.
11a. FATHER'S NAME William Mc Dermott		11b. MOTHER'S MAIDEN NAME Margaret Creighton	12. CITIZEN OF WHAT COUNTRY Ireland
13a. NAME OF HUSBAND OR WIFE None		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Robert Healy 6737 Wise	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular Accident DUE TO (b) Cerebral arteriosclerosis DUE TO (c) 31X Conditions, if any, which gave rise to above cause, (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH 72 hrs
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) June 1962		20f. CITY, TOWN, OR LOCATION St. Louis, Co. Mo.	
21. I attended the deceased from Death occurred at 1:20 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.		21. I attended the deceased from 7/25/63 and last saw him alive on 7/25/63	
22a. SIGNATURE William T. McDonald M.D.	22b. ADDRESS 3915 Watson Rd	22c. DATE SIGNED 7/26/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-29-63	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) St. Louis, Co. Mo.
24. FUNERAL DIRECTOR Kriegshauser So. 4228 S. Kingshighway	25. DATE RECD. BY LOCAL REG. 7-26-63	26. REGISTRAR'S SIGNATURE John B. Murphy M.D.	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK

OR TYPEWRITER RIBBON

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Dr. William T. Fitzgerald  
3915 Watson, MI. 7-4221

after 11 AM

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*James R. Dunn*

Licensed Embalmer No. 4527

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.